



recentermassage@gmail.com
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206-714-9751
Philadelphia, PA

Health History Intake

Personal Information

Date _____

First Name _____ Last Name _____

Gender Preference/Pronouns (circle one): He/Him She/Her Other _____

Date of Birth (mm/dd/yyyy) _____ Phone _____

Address:

City _____ State _____ Zip/Postal _____

Email _____

How did you hear about ReCenter Massage?

Emergency Contact

Name _____ Phone _____

Relationship to You: _____

Additional Contact Info

Health Information

Reason(s) for visit/ Main Concerns:

Current Symptoms (ie swelling, heat, limited range of motion, difficulty gripping etc)

How would you describe your concerns today? (circle any/all that apply)

Pain Ache/Sore Stiff Sharp/Stabbing Pins & Needles Numb Dull Throbbing
Bruised Tight Dizziness Headache Migraine Sprain/Strain Fracture Anxiety

List all past surgeries/operations and include dates if possible (this includes deliveries, teeth work or cosmetic surgeries).

List any/all Medications you are currently taking...

*Please note, if you are taking **pain killers** or **muscle relaxers** for any reason it is **essential** to let your therapist know as it could result in more pain or injury post session if your sense of touch is being affected by the medication.

Do you currently or have you in the past experienced any of the following:

General

- Headaches
- Migraines
- Dizziness
- Concussion
- Congestion
- Insomnia
- Anxiety

Respiratory

- Difficulty Breathing
- Sinus issues
- Circulatory Issues
- Ongoing Cough

Endocrine

- Stomach aches
- Indigestion
- Cramping
- Irritable bowels

Cardiovascular

- High blood pressure
- Low blood pressure
- Diabetes
- Stroke
- Heart Murmurs
- Blood clotting

- Heart attack

Musculoskeletal

- Arthritis
- Fibromyalgia
- Autoimmune disorder
- Ehlers-Danlos Syndrome (EDS)
- Lupus
- Schleroderma
- Dislocation
- Other: _____

Any additional information that is relevant for your massage therapist to know:

Consent and Policy Agreement

Client Agreement

_____ It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Practice Policies

_____ I am responsible for all charges for all services provided. I understand that if I give less than 24 hours notice to cancel my appointment, I am responsible to pay the cancellation fee up to the full amount of the session. I understand that at this time, my massage therapist, Meredith Holladay, LMP and the entity ReCenter Massage and Bodywork LLC, does not bill insurance.

Contract for Care

_____ I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised during the session. I expect my practitioner to provide safe and effective treatment to the best of her skills and knowledge.

Client Full Name (Print)

Client Signature

date _____

Guardian Signature

date _____